Relevant? You Bet!

The Times are a-changin - Where is the HMA on the evolution of managed care in Hawaii? We stand right alongside the AMA insisting on **physician control** of managed care organizations. AMNews top story Jan 20, 1997 reported that for all physicians, the percentage holding managed care contracts increased from 55.7% in 1986 to 69.6% in 1992. I don't think the direction has changed since then. For the young physicians, 0-5 years in practice, the figures are 56.5% and 72%, respectively. Maybe the reason we do not attract young physicians as members is because we are being perceived as a solo-practice-only organization, and the younger physicians are not interested. If we are to represent and be advocates for **all** the physicians of Hawaii, it is necessary that we not take a strong stance on any position that positively affects one group of physicians but negatively affects another. The HMA must support the **freedom of choice** for patients to see the physician they want, and the right of the physician to practice in the situation in which he/she chooses. There are many issues that affect **all** physicians in Hawaii. It is in these issues we find our relevance.

Medical School Hotline

Role of the Clinical Faculty in Pediatric Medical Education

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In 1984, fewer than 5% of all physician-patient contacts resulted in hospitalization. Nevertheless, clerkships for trainees at all levels were predominantly hospital-based inpatient experiences.[1] Over time, academic departments and training programs evolved to be subspecialty based and located in tertiary care centers which had scant contact with the physicians who referred the cases.

Of course, many specialties require a primarily in-patient experience of its trainees; this is particularly true of the surgical fields and most medical sub-specialties. Practice in the primary care areas, on the other hand, is mainly an out-patient experience and becoming increasingly so because of medical advances and other forces including managed care.

Like other primary care specialists, pediatricians have noted that a larger portion of their patients who previously required hospitalization are now routinely managed on an out-patient basis. The combination of the increasingly ambulatory nature of pediatrics and the validity of classic, in-patient based training of pediatricians was generating more and more questions.[2]

In Hawaii the Department of Pediatrics at the John A. Burns School of Medicine (JABSOM) is the direct descendent of a community hospital residency program at Kauikeolani Children's Hospital. The program was integrated into JABSOM 24 years ago with Dr. Sherrel Hammar as Chairman and Professor. He made two important decisions which have guided the program since its inception as a university residency: (1) Every in-patient would be a teaching patient and (2) Clinical faculty would be an integral part of the program.

The clinical faculty who augmented the small number of faculty emphasized to the house-staff that patient care is a continuum which starts with an out-patient diagnosis, admission and hospital treatment, and post-hospital follow-up. The manner in which clinical faculty are utilized in the Department of Pediatrics has evolved over the years by observing four principles:

One, all pediatric admissions to Kapiolani Medical Center for Women and Children are teaching patients. Admitting pediatricians, whether clinical or regular faculty are expected to interact with residents of different levels according to a protocol designed to maximize the teaching value of the patient for the resident. (This protocol was redefined at a joint resident-faculty retreat in 1997). This interaction determines the day-to-day management of the patient.

Two, teaching on the general pediatric ward is accomplished by a team of two regular and two clinical faculty members who are assigned one month rotations. Accordingly, twenty-four clinical faculty members spend part of each week-day morning for a month tending to teaching duties.

The residents benefit from the perspective that the clinical faculty can give on inpatients regarding pre and post hospital management, family dynamics and use of community resources. The clinical faculty benefits from the close exposure to residents, regular faculty and the stimulus of working on a hospital service. The Department of Pediatrics experiences no difficulty in obtaining volunteers for this duty.

Three, clinical faculty members provide community-based ambulatory experience for residents as well as medical students. In contrast to the hospital based ambulatory experience which provides care for children who need primarily ongoing sub-specialty care, the community-based ambulatory experience focuses on continuity, wellness, family dynamics and common illnesses which are managed in the office.

The community-based ambulatory experience with clinical faculty members offers residents more than patient management. It is their introduction to office practice. Residents have their choice of practice setting from solo or small group practice to large staff-model multi-specialty groups. Residents are exposed for the first time to considerations regarding an office's physical design; business aspects such as employee matters, accounting, billing and collections, and medical records systems; appointment systems and telephone techniques; patient flow; purchasing; and office meetings. Residents can also learn about issues which confront physicians such as division of responsibilities, decision making, continuing medical education and dividing income; nursing job descriptions; special office areas (hearing and vision screening, minor surgery); office laboratory procedures and relations with local specialists such as pharmacists, school counselors and other community resources.[3] The rotation can be tailored to address each resident's interests and needs.

Four, clinical faculty who are subspecialists provide rotations in their offices or in the clinic for experience within their sub-specialties.

The validity of the educational approach utilizing clinical faculty and community experience by the Department of Pediatrics has

been established in several ways. The graduates of the program continue to practice successfully in this State in both community and academic settings. In addition, the Residency Review Committee (RRC) for Pediatrics requires increasing amounts of community-based experience of pediatric trainees. Finally, Pediatric Education in Community Settings is the topic of an increasing number of papers and seminars.[4]

Ironically, many of our best clinical faculty are not well known in the hospital. These are physicians who have outstanding out-patient skills and keep their patients out of the hospital. The department hopes to maximize resident exposure to such clinicians. Of course, all clinical faculty are expected to impart their techniques on remaining current in their specialty to the residents.

The role of the clinical faculty in pediatric education is subject to constant evaluation, modification and improvement. The resident initiated faculty-resident retreat of 1997 is the first of what is hoped will be an ongoing process. The faculty must increasingly learn principles of adult education and improve on feedback mechanisms to validate continually the worth of its contributions to resident education.

References:

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Military Medicine

Tragedy in Guam: One Doctor's Chronicle

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In the early morning hours of August 6, 1997, I received a call that began in a manner well familiar. The physician on duty in the emergency room at U.S. Naval Hospital Guam (USNH, GU) called me to request an emergent non-contrast head CT. She was evaluating an elderly male who was found to be non-responsive and a cerebral vascular accident was thought the likely etiology. I asked a few questions about the case and told her I'd be on my way in as soon as I called the CT technologist. The routine nature of the scenario for the late night encounter with my colleagues in the emergency ended with her next declaration. She had just received report of a possible crash of a Boeing 747 passenger plane on Nimitz Hill. I live on the top of Nimitz Hill and had just fallen asleep when she called. I confidently informed her that no plane had crashed into Nimitz Hill. I surely would have awoken at the sound of such a disaster, particularly if one of the monstrous 747s that rumble over my house many times a day was involved. I called the CT technologist and dressed, with little thought of the tail end of my discussion with the ER. As I opened my back door the smell of jet fuel filled the air.

My route to the hospital takes me by a look-out in front of the last stand of the Japanese Imperial Army on Guam in World War II. The vista is usually of the non-inhabited, jungle-covered side of Nimitz Hill, as it slopes into a ravine. Through the light rain, the entire side of the hill seemed engulfed in flames. A Guam Police car had pulled over and an officer was standing in the road. As I approached his face spoke horrification. I stopped and realized that I was the only Radiologist for the hospital closest to a disaster the size of which I could only guess. I continued to the hospital. I provided visual confirmation of the crash and the entire hospital staff was recalled. The mass casuality drills we so diligently practice on Guam was now 'the real thing'. The crash site was difficult to access. The rescue effort was completed in a cooperative manner by the United States Military and local civilian fire and rescue personnel.

As the sole Radiologist I remained predominately in the Emergency Department. A barrage of requests were relayed from the five emergency department exam rooms. Order was made of the requests and films were completed and interpreted rapidly. The urgency to interpret a large number of films rapidly while continuing to coordinate the radiographic triage did not allow me to sit in a dark quiet room with my Dictaphone. I read the films standing at the ER view box with surrounding light and mass commotion, accented by agonizing screams. I gave verbal reports to the physicians, as a technologist wrote my opinion on the film jacker. CT scans were brought for interpretation by runners. We could not spare a portable machine for the intensive care unit. The few stable survivors had their needed X-rays completed in the Radiology department. The identification of patients by name was usually not possible. As practiced in our drills, all patients were assigned numbers as they entered the Emergency Department. This would prevent error in matching patient to films.

Two days following the crash I received another unique phone call. I was informed that I would need to complete X-rays on all of the remains of those who did not survive the crash. The exams would be needed to aid in identification of the victims and would possibly help in assessing the cause of the accident. The senior technologists and I inspected the temporary morgue to assess our unfamiliar task. An enormous warehouse had been partitioned into areas labeled intake, medical photography, personal effects, pathology, anthropology, finger prints, mortuary and data entry/processing. Beneath a sign labeled RADIOLOGY we were to set up shop. As explained by the National Disaster Management System (NDMS) and Disaster Medical Operations Readiness Team (D-Mort) team leaders, the body bags were brought from the crash site in refrigerated tractor trailers. They would be assigned a folder and would pass through each section. We were to open the bags, inspect the contents and complete appropriate radiographs. Anything that might aid in identification was to be recorded. The task was to be completed as rapidly as possible without compromise of information. I knew we would need off-island personnel and material resources to complete the task.

Building a radiology suite at the morgue site was not feasible. We would need three portable X-ray units. Two to run continuously while a third charged. A processor, a label flasher and light boxes